

UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF INDIANA
HAMMOND DIVISION

ROMAN FINNEGAN, et al.,

Plaintiffs,

vs.

LAUREL MYERS, et al.,

Defendants.

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)
) Cause No. 3:08-CV-503
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)

PARTIAL TRANSCRIPT OF JURY TRIAL
OPENING STATEMENTS BY PLAINTIFFS
SEPTEMBER 16, 2015
BEFORE THE HONORABLE RUDY LOZANO
UNITED STATES DISTRICT COURT

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ALSO PRESENT:

Roman Finnegan, Lynette Finnegan,
Tabitha Abair, Johnathon Abair,
Regina McAninch, Tracy Salyers,
Reba James, James Payne, Jennifer
McDonald, and Nancy Webb.

1 (WHEREUPON, proceedings were had and reported, but not
2 made a part of this excerpted record.)

3 (The following proceedings were held in open court,
4 transcribed as follows:)

5 OPENING STATEMENT BY MR. WAICUKAUSKI

6 May it please the Court, ladies and gentlemen of
7 the jury.

8 As the Judge just explained to you, we now have the
9 opportunity to tell you what we expect the evidence to show,
10 and I've prepared a timeline to review a series of events over
11 several years that are at issue in this case.

12 During those years that are at issue, the Defendants,
13 Regina McAninch, Laurel Myers, Reba James, Tracy Salyers, and
14 James Payne, all five of them, worked at the Department of
15 Child Services, or DCS. And as a result of their positions in
16 that Department, they were all vested by law with the power to
17 take children from their parents and from their homes and force
18 them to live with strangers in a strange place.

19 The Defendant Jennifer McDonald is a detective with
20 the Indiana State Police; and as a result of her position, she
21 is and was vested by law with the power to conduct searches, to
22 arrest, to put people in jail, and to press criminal charges
23 against them.

24 And the seventh and last Defendant, Dr. Antoinette
25 Laskey, is a pediatrician with a subspecialty in child abuse;

1 and as a result of her position, she had and has the power to
2 give expert medical opinions upon which critical decisions may
3 be made by police officers and DCS employees.

4 what all seven Defendants have in common is great
5 power. And with great power comes great responsibility, and
6 with that responsibility comes accountability.

7 You will hear evidence in this case about how all of
8 these Defendants used their power to cause severe hardship and
9 unbearable pain to the five members of the Finnegan family who
10 are Plaintiffs in this case.

11 Your task will quite simply be to decide whether they
12 exercised that power responsibly or abused it. You will, in
13 effect, decide whether the Defendants are held accountable for
14 their actions.

15 To understand this conduct, we need to go back 24
16 years to 1991. In fact, it was almost exactly 24 years ago
17 that Jessica Salyer was born.

18 And I don't know whether you can read that on that
19 screen, but in the upper left-hand corner you'll see it shows
20 an entry that says: 1991 to 1996, extensive
21 treatments/surgeries at Riley Hospital in Indianapolis.

22 Jessica Salyer was born 24 years ago this week with a
23 birth defect. She had a heart that was not properly formed
24 completely. One of the valves wasn't working properly, and she
25 was promptly sent to Riley's Children's Hospital in

1 Indianapolis for treatment by expert cardiologists and heart
2 surgeons there.

3 And over the next five years, she had two major
4 surgeries, two major open heart surgeries, to treat that heart
5 birth defect, which, in effect, left her with a functioning
6 heart, but it only functioned with two chambers. I didn't know
7 it was possible either, but they have a Fontan procedure that
8 makes that happen.

9 Jessica Salyer was born to her mother, Lynette.
10 Lynette had two older children, who were healthy and fine, and
11 she made sure, though, that Jessica got the treatment at Riley
12 Children's Hospital in Indianapolis, although it was more than
13 a hundred miles away from her home in Northern Indiana.

14 She did it over five years with numerous treatments,
15 numerous hospitalizations, and then in 1996 the last operation
16 was done. The second Fontan procedure was done. Jessica's
17 heart, though not completely normal, functioned fine.

18 But that was not the only problem that Jessica had.
19 Jessica also was born with a seizure disorder. In fact, she
20 was the fourth generation of Lynette's family to have a seizure
21 disorder. Lynette has a seizure disorder.

22 And during the next few years, Jessica, although her
23 heart was now functioning with two chambers, she had some
24 seizures, and they had to get her seizures under control. But
25 with medications for the seizures and with medications for the

1 heart, Jessica became an active, healthy, normal child.

2 The meds were stabilized at a relatively low dose.
3 By the way, I didn't give you that second entry about the
4 seizures and the adjustment of meds.

5 But then by the years 2000 to 2005, everything was
6 stabilized. She was an active child on low dose meds.

7 What happened basically during this period from 1991
8 to 2004 is that, after those initial procedures at Riley and
9 after getting her meds under control, Lynette regularly filled
10 prescriptions and appointments, and we had at that point over a
11 thousand pages of medical records.

12 But Jessica was doing fine, and all she required as
13 of the period of 2000 to 2005 is to keep her meds up and an
14 annual appointment at Riley. She would have a checkup with a
15 cardiologist there. In 2002, she had her annual checkup. In
16 the reports, you'll see she was doing well, and they said, "We
17 would like to re-evaluate in about one year."

18 About one year later, Jessica went back. Lynette
19 brought her back for another checkup, in which she was found to
20 be doing, again, quite well, no need for any treatment, just
21 maintain the meds we're on, re-evaluate in one year.

22 2004, Lynette takes her back the hundred miles or so
23 to Riley for the annual checkup with the cardiologist. The
24 report is, you'll see, she continues to do quite well, would
25 like to see back in one year.

1 And when I say doing quite well, she's riding bikes,
2 she is playing outside, she is roughhousing with her brother.
3 She's an active, outgoing child. She has some limits in hot
4 weather. She has some limits. She can't play varsity sports.
5 But she is, by all appearances, a normal, active, healthy
6 child. And that's really the way she is going into 2005.

7 And in 2005, in the second half, that's when -- wait
8 a minute. I didn't give you those entries there. When this --
9 The 2002, 2003, and 2004 checkups show there on the left. On
10 the right, we're going to go to the second half of 2005.

11 I'm going to show you details about the medical
12 attention that Lynette was giving to Jessica during this time
13 period, and I'm showing it to you because later DCS
14 substantiates medical neglect associated with this time period,
15 when the reality is this: In May of 2005, the Finnegan family,
16 which at that point consisted of Lynette and her husband of
17 about a year, Roman Finnegan, stepfather of the four children,
18 and the four children, Johnathon, who in 2005 is about 17. The
19 second child was Tabitha, who at that point is about 16.
20 Jessica is the third child in line, who is 14 in 2005, and then
21 the youngest child is Katelynn, who is 9 years old at the time.
22 That family moves from in the vicinity of Culver, where they've
23 been in school for some period of time. They moved to
24 Francesville, which is a small community in Pulaski County.

25 They find a house in town not far from a pharmacy,

1 and it's also not far from where Roman works. He's been a
2 career correctional officer with the Department of Corrections
3 in the Indiana Department of Corrections, and he goes to work
4 for the Medaryville facility of DOC.

5 And so they move. They get adjusted to new schools.
6 And in June, they start using a pharmacy in Francesville.
7 Lynette gets Jessica's prescription filled.

8 In July, July 19th in particular, Lynette takes all
9 four children for back-to-school physicals, including
10 Lynette -- excuse me, including Jessica, into the family
11 physician they've been using for a number of years in Knox,
12 Indiana.

13 The day after that back-to-school physical, she has
14 prescriptions filled in Francesville. She fills more
15 prescriptions on September 2nd.

16 On September 7th -- Let's go through those -- Let me
17 go back one day there before we talk about September 7th.

18 On September 6th, DCS receives a call from the school
19 nurse. Jessica and the others are going to school for the
20 first time. Lynette meets with the school nurse and others and
21 explains to the school nurse that Jessica has some medical
22 issues associated with the heart defect at birth, et cetera.
23 Discusses it with the school nurse.

24 But the school nurse seems to think following that
25 discussion that Jessica needs surgery, that Jessica has had an

1 appointment with her cardiologist in Indianapolis and failed to
2 show up for that appointment and also seems to think that
3 Jessica doesn't have insurance.

4 So she calls DCS, reporting those purported facts --
5 none of them were true -- reporting that. And DCS then calls
6 the Finnegans on the morning -- excuse me, on September 7th.
7 Actually, they call about 1:00 in the afternoon about the
8 concerns expressed by the nurse.

9 Following that phone call -- Actually, let me just
10 read to you a letter or portions of a letter that Roman wrote
11 to his State representative after this call from Regina
12 McAninch. He wrote:

13 "Dear Mary Kay Budak: I'm contacting you in regards
14 to a situation my wife and I had today. We received a
15 call from a child protective service worker from Pulaski
16 County in regards to her daughter -- that's Lynette's
17 daughter -- Jessica Salyer. The case worker called and
18 commented to my wife, 'You don't care about your
19 daughter.'"

20 "When my wife mentioned that she, my wife, has
21 Epileptic seizure, the woman insinuated that my wife was
22 incapable of caring for her daughter. This call was
23 received while we were asleep and not at all prepared for
24 this confrontation, by the way."

25 During this time frame Roman works a shift that

1 starts at 4:00 p.m. and ends at midnight Central time. When he
2 comes home from work in the early morning, he's still kind of
3 wound up. He doesn't get to sleep for a while. Lynette gets
4 up early and gets the kids off to school, but then they sleep
5 in during the day. That's their routine. So when they call,
6 they're sleepy; and that's why they're sleeping in during the
7 day, because he essentially works at night.

8 Roman continues in this letter to his legislator.

9 Next he reports, "My wife became frustrated and hung
10 up on Ms. McAninch." Then he says next, "I answered the
11 phone, she called back, and introduced myself as Lynette's
12 husband. The caller asked where I worked and if I had
13 insurance. When I attempted to explain the situation, she
14 became accusatory."

15 A little bit later in the letter he explains, "When I
16 gave the phone back, back to Lynette, the caller rudely
17 proclaimed to my wife that we had a 9:00 appointment on
18 September 9, 2005," that's a day-and-a-half later, "with
19 no regard to our schedule or ability to be present."

20 "This woman," this is in the letter, "has no idea how much
21 added stress and burden she has created for us. She has
22 invaded our privacy and insulted us with her
23 unprofessional demeanor."

24 He continues, "I also called later that day." This
25 is September 7th, 2005. "I also called the Pulaski office

1 and talked to the Director, Laurel Myers," who is also a
2 Defendant in this case, "and said" -- and let me get this
3 precise, "that in my 15 years with the Department of
4 Corrections, I've never talked to an offender in the
5 manner that my wife and I have been talked to today. I'm
6 hoping that you can either provide help or intervention.
7 Thank you for your time and consideration. Sincerely,
8 Roman Finnegan."

9 After he sent that letter, the letter got forwarded
10 to the Governor's office, then got forwarded to the Defendant
11 James Payne, the Director at DCS, and then got forwarded to
12 Laurel Myers, back at the Winamac office of DCS.

13 Ms. Myers responded to this letter by saying that
14 Ms. McAninch was not in any way rude; and Mr. Payne, after
15 getting feedback from Ms. McAninch and Ms. Myers, responded
16 that the local department had acted -- this is in a letter he
17 wrote to Roman Finnegan, quote, "in a manner consistent with
18 State law and best practice standards." That's what Mr. Payne
19 and Ms. Myers said was appropriate.

20 Now, they proceeded to continue with the
21 investigation. They had the meeting on Friday, September 9th,
22 and there, Roman Finnegan and Lynette Finnegan explained, one,
23 "I work for the Department of Corrections. I have high quality
24 insurance with Anthem. The notion we don't have insurance is
25 just not true."

1 They explained that the appointment at Riley that
2 summer, this annual checkup that you should do about then, was
3 canceled by the doctor. There was no no-show. It was canceled
4 by the doctor, and they were getting it rescheduled, once they
5 had gotten settled in and got adjusted to their new environment
6 in Francesville. That all of the reasons for concern being
7 expressed by the nurse were really unjustified.

8 That's what was exchanged. That's what was learned.
9 They were concerned that the appointment be made. In fact,
10 what happened in the ensuing days was that on the 14th,
11 September 14th, after this meeting on September 9th, Lynette
12 takes Jessica to the family doctor, Dr. Bartush, in Knox, for
13 blood work to prepare for the meeting with Dr. Hurwitz, the
14 pediatric cardiologist in Indianapolis.

15 When I say blood work, you're going to hear during
16 the course of this trial a lot about something called an INR
17 test, or an International Normalized Ratio. It's a test to
18 determine the coagulation of blood. When you're on a
19 medication called warfarin or Coumadin -- Coumadin is the brand
20 name. warfarin is the generic name. It's a drug that thins
21 the blood, that reduces the coagulation level of the blood.
22 And it does so in a non-linear way. You never know with a
23 particular person what the reaction is going to be, so you need
24 to test on some sort of routine basis and particularly whenever
25 you change the dosage to see what the effect is going to be on

1 the coagulation of that particular person.

2 So before Lynette took Jessica to see Dr. Hurwitz,
3 she had this done. On September 14th.

4 The next day, she took Jessica down to Indianapolis.
5 Actually, Lynette, because of her seizures, didn't drive. Most
6 of the driving was done by Roman Finnegan throughout this time
7 period. He's the one that drove her down to Riley.

8 Had the checkup, and what the checkup revealed was
9 essentially the same thing that had occurred in the prior three
10 years. Jessica was doing, in his words, quite well, said that
11 we should have another re-evaluation in one year. It was just
12 a routine checkup.

13 He did say that, based on the INR level that was
14 found in the drug test on the day before, or the blood test on
15 the day before, that we should increase the dosage for warfarin
16 or Coumadin from 2.5 milligrams to 3 milligrams, a small
17 dosage, to see if we could get closer to the target that he
18 wanted, which was in the 1.8 to 2.5 range under the units of
19 measure that they were. And she was only at about 1.18 in the
20 test that was done the day before.

21 So they got a minor adjustment, a small adjustment in
22 the warfarin dosage. With that new adjustment, Lynette got it
23 filled the next day in Francisville with the new prescription.

24 There was also a rash or something that looked like
25 flea bites that Jessica had over a period of time, and they

1 requested and received a consult with the dermatology
2 department at Riley, and Jessica went back on September 29th to
3 have that done in Indianapolis.

4 On October 3rd, Lynette had additional prescriptions
5 filled. On October 4th, after the adjustment in the dosage by
6 Dr. Hurwitz on September 15th, he requested that they have an
7 INR done within a couple weeks. They did one on October 4th.
8 Lynette took Jessica in for that.

9 The results of that were 1.7. Very close to the 1.8
10 target. The decision was made at that time that we shouldn't
11 adjust it further at this point, we should have another INR
12 test in about a week or so. And eight days later, eight days
13 later, Lynette takes Jessica out of school.

14 She gives a release of documents saying it's for a
15 blood test. She takes Jessica to see Dr. Bartush. Dr. Bartush
16 doesn't do a blood test for reasons that are unexplained. He
17 does, however, at Lynette's request, renew prescriptions. And
18 he gives prescriptions at that time not for 2.5 milligrams of
19 warfarin or Coumadin and not for the new 3.0. He gives
20 prescriptions totaling 7.0 milligrams, more than doubling the
21 dosage.

22 why he does that is unexplained. He doesn't put it
23 in his file, but we have the actual prescriptions that he wrote
24 and signed that day. More than doubling her dosage. And he
25 did not order any INRs.

1 The next day, Lynette fills the prescriptions that
2 she receives from him. By the way, in addition to the
3 prescriptions for warfarin -- Historically Jessica has been
4 treated with three prescriptions. She's been treated with a
5 warfarin prescription, a digoxin prescription, and a Dilantin
6 prescription.

7 The digoxin is another prescription for the heart to
8 help the heart work better at a better rhythm; and Dilantin is
9 the prescription she was receiving prior to October 12th for
10 treatment of her seizures.

11 But when Lynette asked Dr. Bartush to renew or refill
12 her prescriptions, he does not renew the Dilantin
13 prescriptions. He gives the two prescriptions for warfarin and
14 the one prescription for digoxin. She walks out with three
15 prescriptions, which she then takes to the drugstore and gets
16 filled. But she now has no prescription for Dilantin. She now
17 has more than a doubling of the dosage of warfarin. That's not
18 realized by anybody at that time.

19 What is -- what happens, though, is that, after all
20 of these events, and after Lynette refills the prescriptions
21 given to her by the doctor on October 13th and November 18th,
22 on December 5th, the DCS had learned that the concerns were
23 unjustified. DCS did what's called a substantiation.

24 When DCS receives a complaint of child abuse or
25 neglect, they have a responsibility to either substantiate or

1 unsubstantiate. If they find that the evidence by a
2 preponderance of the evidence shows child abuse or neglect,
3 they are to substantiate. If it doesn't, they are to
4 unsubstantiate.

5 They decided on December 5, 2005, to substantiate
6 medical neglect in the face of all this history that you see in
7 front of you. And after Roman has complained to the legislator
8 and the Governor and the others about the rudeness and the
9 manner in which they dealt with this.

10 They don't, however, inform Roman or Lynette that
11 they are substantiating medical neglect. They're certainly
12 going into the records and the child abuse index or registry as
13 child -- as abusers or neglectors of Jessica based on their
14 finding of neglect.

15 And I did think it's important to note that, when
16 I -- as I note in that part of the -- It says Judge
17 unsubstantiates later. I'm going to talk a little bit more
18 about some of the proceedings that came later in this process
19 when the events got even more serious.

20 But this finding of substantiation of medical neglect
21 finally got reviewed by a Judge several years later, and he
22 ruled that it should be unsubstantiated because there was no
23 basis in fact or law to support the substantiation at that
24 time.

25 When I say law, we're going to be talking a lot about

1 child abuse and child neglect, and the Judge is going to give
2 you the law on that. You may see some portions of the welfare
3 manual or the manual that DCS uses as to their operating
4 definition for child abuse. It is when a child's physical or
5 mental health is seriously in danger due to injury by the act
6 or omission of the child's parents.

7 You've got to have physical health seriously
8 endangered due to injury or act or omission. That's child
9 abuse. Child neglect, by their own definition, is when a
10 child's physical or mental condition is seriously impaired or
11 seriously endangered as a result of the neglect of the child's
12 parent, guardian, or custodian to supply the child with
13 necessary food, shelter, or medical care.

14 In this instance, they were substantiating what they
15 said was necessary medical care which seriously endangered the
16 child. And what they said was that DCS wasn't needed to get to
17 their checkups in all the prior years or the thousand pages
18 before, DCS was needed in order to make sure this happened in
19 2005. But that, however, as I've told you, was unsubstantiated
20 later.

21 What occurred then -- That's really just the prologue
22 to the more serious stuff that came immediately thereafter.
23 And actually, it started the same day on that December 5th,
24 2005. At the request of the school, Jessica had some -- two
25 additional vaccinations. They were done at the -- in Winamac

1 at the Department of Public Health.

2 A few days later, Jessica started feeling badly. And
3 on December 12th, she missed school with essentially flu-like
4 symptoms. She was having vomiting and diarrhea and wasn't
5 feeling good.

6 And so the next day after she stayed home from school
7 the first day of December 12th, on December 13th, Lynette took
8 her to see the family doctor, Dr. Bartush, in Winamac. He
9 examined her for the flu-like symptoms, and he prescribed a
10 liquid diet for her to address that.

11 He also found that he thought she had thrush, which
12 was kind of a film he observed within her mouth and he
13 prescribed an antibiotic for that, treatment for that.

14 And the next day, Lynette had that prescription
15 filled in Francesville. Over that week of December --
16 December 12th was a Monday, Jessica stayed home from school
17 with those symptoms. And she had one other thing going on.
18 That week was the week that she started her first period, and
19 she was having cramps and bleeding as a result of that.

20 And the bleeding, as you know, I told you that we had
21 those prescriptions significantly increasing the warfarin. May
22 well have been affected by that. But she stays at home. She's
23 got the cramps. The vomiting tends to go down with the liquid
24 diet, et cetera. But she's not -- she seems to be somewhat
25 better, but she starts developing a little -- seems like she's

1 bit her lip, and she's picking at a scab there, and there's
2 blood arising at times on her lip at that point.

3 But on Monday, December 19th, after she's been at
4 home for about a week -- By the way, when Dr. Bartush saw her
5 on December 13th with the flu-like symptoms, et cetera, he
6 basically said, if she's not doing better in about a week, you
7 know, come back. And a week after that would have been the
8 next day, December 20th.

9 On December 19th, Lynette talks to Roman about
10 Jessica still not healing completely and says, "Look, if she's
11 not better by the next day Roman was off, which was
12 December 21st, we'll go to Riley and see what's going on
13 there."

14 Unfortunately, that never happened because, on
15 December 20th, 2005, after the kids went -- the other three
16 kids went off to school and Jessica appeared to be sleeping
17 fine that morning, that afternoon, about 2:00, Lynette walked
18 into her room and found her lying on the floor on her stomach
19 and tried to -- to arouse her, but failed to do so. She
20 screamed for Roman. He came into the room. He's a CPR
21 instructor. He tried to do CPR while Lynette made a 911 call,
22 hysterical to seek help. An ambulance came. The police came.
23 The deputy coroner came to the scene. But Jessica had died.
24 And that death was then and remains now a heart-wrenching
25 experience for every family member.

1 And this case is not about what caused her death,
2 because these Defendants are not in any way responsible for
3 causing her death, but what they proceeded to do after Jessica
4 died was to make this tragedy far worse in every way.

5 However, there are other professionals who came, were
6 involved in considering what the circumstances were. One of
7 the first professionals that was involved at that point was a
8 doctor in the emergency room at the hospital in Rensselaer in
9 Jasper County where she was taken. He examined Jessica. He
10 called Dr. Hurwitz in Indianapolis to find out what Jessica's
11 situation was. Based on what he knew at the time, he believed
12 and his diagnosis was in his report, which you'll see, sudden
13 death syndrome, congenital heart disease. He also provided and
14 indicated there were no indication here of any abuse or
15 neglect.

16 There were police at the scene. They investigated,
17 as well. They found no bruises indicative of a beating or
18 anything like that. They found no indication of abuse or
19 neglect.

20 The coroner came to the scene. He, likewise, saw no
21 evidence of child abuse or neglect. And the next -- well,
22 actually that day, DCS decided to go ahead and start taking
23 action.

24 They didn't initiate this action on their own. The
25 police, who were at the scene were there when the other

1 children arrived home from school. And the police called DCS
2 to have them come take care of the children because at that
3 point the parents were away at the hospital.

4 And so they took the children to DCS, but didn't just
5 take them. They detained them for about four-and-a-half hours
6 and questioned them at some length about what was going on in
7 the home at the time, about what Jessica was feeling and doing,
8 and they got tape-recorded statements at that time, not the
9 highest quality, of what the other children observed and saw.
10 Nothing indicated abuse or neglect from the other three
11 children that they tape-recorded and interviewed during that
12 four and a half hour detention on the day that Jessica died.

13 The next day, an autopsy was done at the request of
14 the coroner to try to determine exactly what was the cause of
15 Jessica's death. The person who performed the autopsy was a
16 Dr. John Cavanaugh, a forensic pathologist. He did a
17 handwritten preliminary report. In his preliminary report, he
18 noted Jessica had numerous hemorrhages at various points in her
19 body, hemorrhages that indicated to him as he wrote on the
20 report that she had a coagulopathy, that the coagulation of her
21 blood was not correct, she was not -- her blood wasn't clotting
22 like it was supposed to, that's why there was a variety of
23 internal hemorrhages going on.

24 He also said that -- he saw what was a bleeding
25 inside the skull, a subdural hematoma. And he said what he saw

1 with respect to the subdural hematoma in his report was
2 consistent with a fall. As a forensic pathologist, he's
3 familiar with the fact when you have people on warfarin on
4 Coumadin and they fall, they could have a subdural hematoma
5 because their coagulation isn't the same, and that can
6 contribute to or cause death.

7 So he identified that. He identified the
8 circumstances. He said in his initial handwritten report this
9 is consistent with a fall. And then in talking with the other
10 people at the autopsy, the police, the coroner, the deputy
11 coroner.

12 They looked at the body and they said, well, there's
13 some old bruises on the legs, the kind you would expect from a
14 14-year-old teenager, nothing recent, very small, very
15 insignificant. There were no bruises on the upper body or on
16 the face or on the head which would indicate a beating of any
17 kind. They all agreed, every one of those professionals,
18 agreed that there was no evidence of foul play.

19 But that's not what DCS thought. They already
20 substantiated medical neglect, right? And they proceeded to
21 investigate over the next several months.

22 By the way, they questioned Roman and Lynette on the
23 day of her death. They got that indication. They proceeded to
24 do investigations. About a few months later, Regina McAninch
25 sought to get records of the Indiana State Police from an

1 Indiana State Trooper by the name of Duane Datzman. He had
2 come to the scene in order to take photographs and do some of
3 the death scene work.

4 And when Regina McAninch was asking Datzman for their
5 medical records, they had a conversation which went something
6 like this. Datzman didn't understand why they were doing this
7 investigation, saying the pathologist stated she died of
8 natural causes. And Ms. McAninch said, "well, we had a
9 previous medical neglect on this family, and we have a duty to
10 investigate."

11 And Trooper Datzman responded, "I don't know why
12 you're doing this. Whatever." He gave them their report, and
13 she took it, and she got a supplemental -- or an interim
14 report, if you will, from Dr. Cavanaugh that was dated in
15 May, where he talked about some of the circumstances associated
16 with this death in more detail than in the preliminary report.

17 And then in October, the Defendants, McAninch and
18 Myers, arranged to hire the Defendant Antoinette Laskey to
19 review the records and see what she thought based on the
20 records, and Dr. Laskey did that.

21 She reviewed the records that were sent to her by
22 DCS. She talked in the hallway about five minutes to
23 Dr. Hurwitz. She reviewed what the pathologist had said in his
24 interim report, but she didn't call the pathologist. She spent
25 a total of about three hours, roughly three hours in his words,

1 reviewing the records.

2 She wrote a three-page, single-spaced report
3 concluding with this statement. "It is my expert medical
4 opinion that this child sustained a fatal beating on the day
5 that she died and that this beating was the direct cause of her
6 death. I have grave concerns about the safety of other
7 children in the care of the caregivers at the time of these
8 injuries."

9 She sent that to Ms. McAninch and Ms. Myers on
10 October 31st. Ms. McAninch said in an e-mail about the same
11 time, "Thank Heaven someone other than the local director and
12 FCM agree this child died from physical abuse."

13 That's October 31. Thank Heaven -- This is now ten
14 months after the death. The only people who think there's
15 physical abuse going on here is Ms. McAninch, Ms. Myers, and
16 now they've got a pediatrician to sign onto that, who doesn't
17 consult with the pathologist and who renders this opinion after
18 three hours of work.

19 So what do they do? well, the next thing they do is
20 they seize the girls. The very next day after getting
21 Dr. Laskey's report, they come and take Tabitha and Katelynn
22 and take them off not to relatives, but to a foster home out of
23 the county, out of school, away from their homes, away from
24 their families, away from their friends, seizing them.

25 why do they do it? Ms. McAninch says she does it --

1 obviously she says because she's initiated this in part, but
2 she says she's been directed to do this by her director,
3 Ms. Myers.

4 Ms. Myers, when asked about it, says that she does it
5 because the removal was ordered by the Defendant, James Payne,
6 the Director of DCS.

7 Ms. McAninch then two days later tells a Judge why --
8 when asked, "Why are you detaining the children," she says
9 because of Dr. Laskey's report about the fatal beating and
10 grave risk of the children and quote, "to continue our
11 investigation," end quote.

12 They wanted to question Tabitha and Katelynn further,
13 and they proceeded over the next several months to do that.
14 After putting the girls in foster care, they did something that
15 I think is fairly characterized as investigative therapy. They
16 used the counselors or the therapists for the children to ask
17 questions about their sister's death for investigative
18 purposes.

19 The result was uncontrolled stress by the children.
20 The result was, to make matters worse, neither of the girls
21 ever said anything that in any way indicated there was abuse or
22 neglect here in any meaningful way.

23 But once the girls got seized, Roman started to,
24 "what's going on here?" We got a doctor saying that there's
25 been a fatal beating on the day of death. He starts to try to

1 figure out what is going on here.

2 And he finds an attorney in Seattle by the name of
3 Heather Kirkwood who does work of this kind for other people,
4 and she says, "Well, have you checked the pharmacy records?"
5 And he goes and gets the records at the Fagen Pharmacy there in
6 Francesville near their home, and that's when he finds that the
7 pharmacy records show that the prescriptions that have been
8 filled are for warfarin that's substantially greater than it
9 had been before. They also show that these had been refilled
10 and that for about two months she's been on an overdose of
11 warfarin.

12 That wasn't known to DCS before they -- Their
13 extensive investigation didn't go so far as to get the pharmacy
14 records of the meds that she was on that might relate to
15 hemorrhages.

16 But within a couple weeks after the girls are taken,
17 the pharmacy records are obtained. They show what appears to
18 be a prescription error and an overdose of warfarin, that that
19 explains it, and they proceed to provide that information on
20 December 13th to DCS.

21 And Dr. Laskey receives that information on
22 December 18th. Dr. Laskey has assumed that Jessica has been on
23 her same dosage of -- the dosage that Dr. Hurwitz had ordered
24 back in September of 3.0. But now the records show it's more
25 than double that, and apparently without any reason and without

1 any INR testing going on.

2 But that doesn't seem to dissuade DCS or the
3 Defendants or Dr. Laskey. So more information is gathered.

4 Roman and others find out that there's an expert on
5 medical errors, on pharmaceutical errors, who teaches in the
6 pharmacy department at the University of Illinois, Professor
7 Bruce Lambert.

8 They ask him to take a look at it. He examines it.
9 He does a declaration which is provided to DCS on January 4th
10 or shortly thereafter -- that's when the declaration is
11 dated -- in which he explains, among other things, that
12 warfarin overdose is a potential cause of this death that you
13 should be considering now that we've got this evidence.

14 They also obtain a declaration from a Dr. Innis.
15 Dr. Innis is a hematologist. That's a doctor who specializes
16 in blood issues, including coagulation issues. Dr. Michael
17 Innis is based in Australia. He does a declaration that
18 explains, in his opinion based upon the records that he's
19 reviewing now, that to a reasonable degree of medical
20 certainty, Jessica's death was the result of an undetected
21 complication of Coumadin therapy.

22 By the way, these experts are doing this work on a
23 pro bono basis. They're not saying it because some lawyer is
24 buying them. They're saying it because they're looking at the
25 records, and that's the conclusion they're reaching. It's

1 being shared with DCS, but it doesn't dissuade them.

2 And then we've got some other things going on about
3 this time. One of the things that happens -- I didn't note on
4 November 1st, after Dr. Laskey sends her report on October 31,
5 in addition to seizing the girls, they convince the State
6 Police to start an investigation.

7 They've closed their files a long time ago, but now
8 we've got this report from Dr. Laskey, and they assign a
9 relatively new detective. Been in the business, doing this
10 work for about a year by the name of Jennifer McDonald. She is
11 here as a defendant. She begins her investigation on
12 November 1st.

13 And on January 15th, as part of her investigation,
14 she conducts a search of the Finnegan home to get a table in
15 order to match what she sees as interior bruising or bleeding
16 inside Jessica's head. You will hear evidence that the whole
17 idea is ridiculous, but that search was done at her instigation
18 on that day.

19 Also at her instigation, there was a search done on
20 January 25th. Jessica's body was exhumed, pulled out of the
21 ground, for a second autopsy.

22 Detective McDonald had seen a presentation by a world
23 famous pathologist, Dr. Michael Baden, and he offered to come
24 out and help State Police do investigations, and she contacted
25 him. He agreed to come out and do an autopsy of Jessica's

1 body, and he did that on January 25th. The results of his
2 autopsy were, in essence, no significant findings. That's what
3 the coroner reported when he issued his report not long --
4 well, later that year. This is now 2007.

5 But McDonald is not only doing searches of the home
6 and exhuming the body and having autopsies done. She also is
7 interviewing the children, and on January 29th, she does an
8 interview of Johnathon, the older brother.

9 And in this interview of Johnathon, she takes
10 significant liberties with the truth. She thinks this is an
11 appropriate investigation tactic, to talk to the child of
12 Lynette and Roman.

13 And she tells Johnathon, who at this point is about
14 18, tells Johnathon that his mother, Lynette, has accused him
15 of causing Jessica's death, of killing Jessica. Lynette and
16 Roman never said anything of the sort, but she thought she
17 could get Johnathon to turn on his parents by telling him that
18 lie.

19 Johnathon didn't turn on them in any way, but he
20 did -- he did call his parents after that interview, when the
21 State Police is telling him that they've accused him of killing
22 his sister.

23 He is almost hysterical himself. He's upset that
24 they would do such a thing. He doesn't want to ever see them
25 again. And the relationship between Johnathon and his parents

1 for the next several years is either non-existent or extremely
2 strained as a result of the lie told by Jennifer McDonald. She
3 thinks it's okay to kind of stretch the truth, if you will, in
4 order to serve the greater mission of her criminal
5 investigations.

6 while Jeanette -- excuse me, Jennifer McDonald is
7 carrying on her investigation in those fashions, Roman and
8 Heather Kirkwood are continuing to try to gather evidence that
9 would be pertinent to this matter.

10 In fact, Heather Kirkwood creates three volumes of
11 information, three large binders, over 800 pages of material,
12 including all the medical records of Jessica, all the medical
13 literature that tends to confirm exactly what appears to be
14 going on here, which is a warfarin overdose, and how it
15 manifests itself and results in -- may well result in a fall
16 that causes death. And then she also provides these expert
17 opinions, in the binders, from Dr. Lambert and Dr. Innis as
18 well as a number of other declarations which you will see in
19 this case, but significant material provided to DCS on or about
20 March 1, 2007. They ignore it. They don't care what the
21 facts are.

22 On March 23, three weeks after giving this
23 information, after learning about the prescription overdose,
24 after learning about the implications of that, they
25 substantiate death from physical abuse.

1 They've got the job to substantiate or
2 unsubstantiate. They substantiate there is death here by
3 physical abuse from Lynette and Roman based on that
4 investigation.

5 This substantiation does not mention the prescription
6 error. It doesn't mention that throughout this time the
7 forensic pathologist who had done the autopsy believed that, to
8 the extent there were injuries, they were all consistent with a
9 fall. Doesn't mention the fact that, when you have a warfarin
10 overdose, the symptoms are very much the flu-like symptoms, not
11 discernible to an ordinary person.

12 But they did. That's what they substantiated on
13 March 23rd.

14 On March 17th, there is another report by Detective
15 McDonald, recording some of the things that she finds during
16 her investigation.

17 She writes this report and destroys all of her notes
18 that she has, a report that was in many respects false. She
19 writes in this report that Tabitha and -- the children say that
20 Jessica had been begging to go to the hospital the night before
21 she died. The children never said that, but it's in her
22 report.

23 You got the tapes the day -- the day of her death.
24 They never say anything like that. But it's in her report, and
25 her notes are destroyed.

1 And she writes this report, and then she goes to get
2 arrest warrants. And if things weren't already bad enough, on
3 April 24, 2007, she obtains arrest warrants for Roman and
4 Lynette. They are arrested, and they are jailed on criminal
5 charges. She does the probable cause affidavit based on her
6 investigation.

7 You're going to hear some of the details about that
8 arrest because Roman and Lynette were supposed to be meeting
9 with a prosecutor that day to kind of explain why there was no
10 basis for this, but instead, they get arrested.

11 And then they get arraigned in circumstances where
12 Lynette is shackled and is forced to hop upstairs outside the
13 courthouse in an incredibly shameless set of circumstances
14 initiated by Detective McDonald.

15 And, in fact, the day after this arrest, Detective
16 McDonald issues a news release, and the Indiana State Police
17 do, in which she attributes this result to Dr. Baden's autopsy,
18 when he never does a report and never made any significant
19 findings.

20 But that's what she does. And it's widely publicized
21 that these two, the parents, are now being accused of
22 responsibility for the death of their daughter.

23 After that, Roman and Heather and Lynette continue to
24 search for evidence. They talk to Dr. Edith Nutescu, who is an
25 expert on coagulation and anti-coagulation treatment.

1 She looks at these records. She does a declaration
2 explaining that, when you have warfarin overdose at this level,
3 you are particularly prone to bruising. You're going to have
4 bruises if you're on warfarin, especially if you're on a
5 warfarin overdose. There are no bruises indicative of beating
6 whatsoever. It's completely inconsistent with it, as she makes
7 clear in her declaration. This was a prescription error, and
8 to suggest that there's a beating in these circumstances is
9 just unwarranted.

10 They also obtain a declaration from a Dr. Heinsen, a
11 family doctor in winamac, because at this point they're trying
12 to get the children out of foster care. They've been there now
13 for seven months, and he says, "Look, the children are not in
14 danger. I'll make sure they're not in danger if you're
15 concerned about it," but they pay no attention to that.

16 They obtain a declaration from Dr. Jan Leestma, a
17 neuropathologist in Chicago who looks at all these
18 circumstances, and he says, "Look, this evidence here is death
19 due to warfarin overdose. It's not death due to beating.
20 You're going to have bruising. The circumstances here of the
21 warfarin overdose explain what's going on here."

22 On June 27th, they learn, after all this evidence has
23 been developed, that Laskey is not going to testify for them
24 any longer. She says, "I really don't know that much about
25 Coumadin or warfarin, and I'm not going to testify for you in

1 support of this detention of the children or the petition
2 that's been filed for Child in Need of Services."

3 A declaration is also prepared by Dr. Krupsaw about
4 the damage from -- from the investigation therapy that has been
5 going on for years and how that's unethical for them to be
6 doing that.

7 There's a declaration by Dr. Pless that's provided.
8 Dr. John Pless is a forensic pathologist who had been at the IU
9 Medical School for a number of years who trained, among others,
10 Dr. Cavanaugh. He looks at the facts and circumstances, and
11 concludes there's no evidence here of beating or abuse.

12 Dr. Cavanaugh sends an e-mail on July 11th explaining
13 to DCS that there have now been some slides done that show the
14 age of the bleeding that had occurred in the subdural and other
15 parts of the body, and it showed this wasn't a case of bleeding
16 on the day of death. This was a case where bleeding had been
17 occurring over days or weeks as demonstrated by these slides.
18 He also said he had new information with respect to time of
19 death. And after they get that e-mail, they cancel Cavanaugh's
20 deposition.

21 Now, they will tell you that they did this because
22 Dr. Cavanaugh mentioned in his May 20th report, May of 2006
23 report, that there was a skull fracture. And there is mention
24 of a skull fracture in that report. They had asked
25 Dr. Cavanaugh, he said it's all consistent with a fall. "I see

1 a subdural hematoma. I see some other injuries here that
2 reflect a fall, and a skull fracture occurs with a fall, and
3 this is all consistent with a fall." And they say it may not
4 be consistent with a fall from 2 feet rolling off the bed, but
5 it's consistent with a fall. He never suggested there was any
6 abuse, any neglect at any time.

7 From the point of the initial autopsy, he says it's
8 undetermined in terms of whether this is an accidental death,
9 where somebody tripped and fell or maybe a medication error or
10 whether it was a natural death because she had a seizure; and
11 as a result of the seizure and these other complications, it
12 was a natural death. From day one, his opinion was there's no
13 evidence here of foul play.

14 Dr. Laskey is interpreting the report as well as the
15 other Defendants without any basis in fact or supported by the
16 actual author of the report.

17 And by the way, with respect to that skull fracture,
18 there will also be evidence that, at the time of the initial
19 autopsy, everybody in the autopsy room heard a pop as
20 Dr. Cavanaugh was cutting into the skull. They all believed
21 that, to the extent that there were fractures in the skull, it
22 was an artifact of the autopsy at the time.

23 Dr. Cavanaugh, for him, it never really mattered
24 whether it was an artifact of the autopsy or not because there
25 was no evidence of abuse, the lack of bruising, et cetera.

1 Never indicated foul play. But when he looked at the skull
2 after he had cut into it, there was a fracture, and so he felt
3 it was his duty to record the fracture. He believed it was an
4 artifact of the autopsy initially.

5 When Dr. Baden came in and they looked at it a second
6 time, there was some blood inside the fracture, and he
7 thought -- Dr. Baden thought that one of the fractures may have
8 preexisted. Still never thought it was of any consequence
9 because it was all consistent with a fall. It was not
10 consistent with a beating.

11 They also use the words -- Dr. Cavanaugh used the
12 words blunt force injury of the head, which he will tell you
13 when he testifies that he means simply that, when you have a
14 fall and there's an impact that results in something like a
15 subdural hematoma, you have to have some impact, not a beating,
16 but some sort of impact, like a fall, and that's called blunt
17 force injury.

18 And he describes the direction of this fall or this
19 injury and the words pile driver force at one time. At the
20 same time he says it's consistent with a fall; it's essentially
21 the body is flowing after the head.

22 At no time does he suggest that any of the things
23 mean there was anything other than an accidental or natural
24 death. But that's what they are keying on.

25 At no time does he determine that this is a homicide,

1 but that's what they, the pediatrician and the DCS workers,
2 conclude, and Detective McDonald pursuing criminal charges.

3 So on December -- excuse me, July 17th, 2007, the
4 coroner, Gordon Klockow, renders his verdict in this case.

5 It's his job to determine the cause of death whenever
6 there's a questionable death. He does an extensive report, and
7 he renders a verdict, saying this death was an accidental death
8 due to prescription errors.

9 In his opinion, to the extent there's a skull
10 fracture, it's an artifact of the first autopsy. He was there.
11 He heard the pop. He sees the evidence.

12 And by the way, Dr. Leestma and Dr. Pless and others
13 all think it's an artifact of the first autopsy. Dr. Cavanaugh
14 thinks one of them is likely in his opinion to have preexisted,
15 but in his mind it is and never was of any consequence.

16 But that's his conclusion.

17 And the next day, there's finally going to be a
18 hearing, a fact-finding hearing as to why the girls are in need
19 of services or not, why they should need to be detained or not.

20 Roman and Lynette and their attorney, Heather
21 Kirkwood, have gathered 22 witnesses for this hearing. In
22 defense of their position on July 18th, DCS, Ms. Myers,
23 Ms. McAninch, Mr. Payne, for this hearing they have zero
24 witnesses. Zero. But they maintain the substantiation. They
25 keep the girls. Although they do in the course of that week

1 agree to finally allow the girls to return home.

2 And on July -- Excuse me, August 9th, 2007, after
3 nine months of being away from their family, away from their
4 home, away from their school, they're finally allowed to
5 return. But they're allowed to return with DCS still requiring
6 what they call a reunification plan.

7 In this reunification plan, they require an
8 assortment of services DCS provides, an assortment of services
9 that is nothing less than harassment. They have people coming
10 to their home, several people, on a daily basis, up to four
11 hours a day, supposedly to help them. They are not able to
12 return by any means to normal family life because of this
13 reunification harassment by DCS that starts upon their return.

14 The prosecutor finally comes around and dismisses
15 these charges that Detective McDonald has instigated. On
16 October 24th, she dismisses the charges against Roman. On
17 November 2nd, she dismisses the charges against Lynette.

18 On November 8th, there is an interesting hearing.
19 There's a motion that -- The coroner has been trying to work
20 with DCS in connection with his investigation. They have not
21 worked in return, and the coroner gets DCS found in contempt
22 for resisting his investigation, to get to the bottom of this,
23 of what caused Jessica's death.

24 Finally, on November 27th, 2007, after all that, DCS
25 dismisses the CHINS case, acknowledging that there was no basis

1 for it.

2 But then, on December 13th, 2007, after all of that
3 evidence, after no evidence to the contrary, they have a
4 procedure called administrative review.

5 We still have the substantiations from March 23rd,
6 2007 saying this was death due to child abuse. They still have
7 it. And what they have is an administrative review. They've
8 got an opportunity to ask in this instance Reba James, the
9 manager over Laurel Myers, to review it and reach her own
10 opinion as to whether this should be substantiated. She not
11 only confirms the substantiation. She adds two more charges.

12 In the next few months, January to April 2008, after
13 having this adverse result from Reba James in the
14 administrative review, Lynette and Roman attempt an
15 administrative appeal. They're still on the registry as child
16 abusers.

17 And they identify all of the medical experts who are
18 going to testify on their behalf. DCS has none. And there's a
19 decision made at that time that this matter is going to be not
20 handled in the administrative review process but will have a
21 judicial review by an independent Judge in Pulaski County.

22 And in due course, an 8,000 page record with all this
23 evidence is gathered. They agree that's the record to be
24 considered by Judge Blankenship; and after all of that, on
25 January 28th, 2010, he reviews it. He considers everything

1 that these Defendants through their attorney have to offer to
2 substantiate these claims, and what he finds is that they
3 should all be unsubstantiated. They should all be
4 unsubstantiated, and these are his words because those findings
5 are arbitrary and capricious. There was no evidence or facts
6 to support them.

7 So we've asserted civil rights claims. We've
8 asserted civil rights claims under the First Amendment because
9 when Roman sent his letter, his petition to his legislator, to
10 the Governor, to say, look, there's something wrong here, and
11 what he gets in response is substantiated medical neglect, and
12 this course of conduct, that's a retaliatory conduct that
13 violates that amendment.

14 We've asserted claims here under the Fourth Amendment
15 that say searches have to be reasonable, they have to be based
16 on evidence and fact, and the searches that were conducted here
17 and the seizures that were conducted here, the seizure of the
18 arrest, the false arrest, the seizure of the detention of the
19 girls that extended for nine months, the detention even on the
20 day of the event, the exhumation of Jessica's body, they all
21 violate the Fourth Amendment's prohibition against unreasonable
22 searches and seizures.

23 Maybe most importantly is the claim under the
24 Fourteenth Amendment. That's the claim that says every parent
25 and every child has a fundamental interest in the companions

1 and society of the other in these familial relationships, and
2 they cannot be separated by government other than in emergent
3 situations or to protect the child against imminent danger.

4 This substantive due process, the evidence will show,
5 establishes that is violated by the seizing of Tabitha and
6 Katelynn without probable cause to believe that they were in
7 any danger, detaining them for nine months for purposes of
8 investigative therapy, for providing false reports and
9 concealing exculpatory evidence in order to continue this
10 detention, to tell Johnathon and his sisters that their mother
11 had murdered their sister and to tell Johnathan in particular
12 that his mother was accusing him of killing his sister, and
13 thereby deliberately and systematically destroying family ties
14 and relationships.

15 You'll hear considerable evidence in this case about
16 the damages that those actions caused to each of these
17 Plaintiffs, and I won't detail them for you now, but you'll
18 hear about them over the next two weeks. And at the end of
19 this case, I will ask you, based on the violations of those
20 civil rights and that course of action, to return a verdict for
21 full and fair compensation for the damages that were done to
22 each member of this family.

23 And I will also ask you to return a verdict for
24 punitive damages because that's the kind of damages that's
25 available to tell these Defendants and others in similar

1 positions that this isn't acceptable in Indiana, to give that
2 message by providing a punitive damage, as well. Thank you.

3 * * *

4 (WHEREUPON, this concludes the partial transcript in this
5 case on this date.)
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CERTIFICATE

I, Angela Phipps, certify that the foregoing is a correct transcript from the excerpt of the record of proceedings in the above-entitled matter.

Date: SEPTEMBER 30, 2015

S/Angela Phipps
S/Angela Phipps
Court Reporter
U.S. District Court